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BUREAU TALK

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Inside this issue:

Medicare Administrative Contractors (Macs)	2
Most Frequently Cited Tags on Survey	2
Most Frequently Cited Tags on Survey Cont.	3
Volunteers	3
Stay in the Loop	3
Show Me Home Care and Rehab	4
Discharge for Cause	4
LPN Supervision	5
Haldol for SNF Hospice Patients	5
Haldol for SNF Hospice Patients Cont.	6
OASIS News	6
Bereavement	6
Standing Orders	7
2008 Annual Reports	7

STATE HOSPICE REGULATIONS

The amended **State Hospice Regulations** were published in the Code of State Regulations February 29, 2008, and became effective March 30, 2008. As with any new regulation, the Bureau of Home Care and Rehabilitative Standards tries to give agencies a 3-month grace period. It is expected that all hospice agencies will have a new policy written and in force by July 1, 2008 to assure yearly Alzheimer training of staff. The primary changes in these regulations are related to are in the area of Alzheimer's Training and Hospice In-patient pharmacy procedures. (A copy of the new State Hospice Regulations can be found in **Attachment #1**)

FEDERAL HOSPICE REGULATIONS

The Bureau is aware that all hospice agencies are anxiously awaiting the release of the new Federal Hospice Regulations. The planned release of these regulations has been slated for May 2008. At this time, the Bureau is unaware of any change in this plan.

FEDERAL, STATE & LOCAL LAWS

As you can see from the tables listed on page 2 and 3, outlining the most frequently cited tags for the past year (April 07 – April 08), one area that repeats itself for both home health and hospice are the tags associated with following federal, state, and local laws. (G118, M113, M114). Therefore, the Bureau felt it would be of benefit to again share with all agencies our "cheat sheet" outlining the federal, state, and local laws that are mandated for home health and hospice. (**Please see Attachment #2**) However, when reviewing Attachment #2, all **hospice** agencies need to keep in mind that, at this time, Family Care Safety Registry is not a requirement for hospice. Please note that the new State Hospice Regulations includes yearly training of staff on alzheimer's and dementia. See attachment 1.

MEDICARE ADMINISTRATIVE CONTRACTORS (MACs)

Per the CMS website http://www.cms.hhs.gov/MedicareContractingReform, "CMS' mission is to ensure health care security for beneficiaries. A major component in achieving this mission is the successful administration of Original Medicare, or Fee-for-Service (FFS) Medicare. Medicare Contracting Reform (or section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) is a major component in achieving this mission. Section 911 mandates that the Secretary for Health & Human Services replace the current contracting authority to administer the Medicare Part A and Part B FFS programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new Medicare Administrative Contractor authority. Through the implementation of Medicare Contracting Reform, CMS will establish a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider service."

Under this law, CMS is required to replace the current Medicare Fiscal Intermediaries and Carrier, using competitive procedures, with new Medicare Administrative Contractors by 2011. It is believed that by September 1, 2008 the fiscal intermediaries for home health and hospice will be replaced by a Medicare Administrative Contractor (MAC). The MAC is the new contracting entity that will be responsible for the receipt, processing and payment of Medicare fee-for-service claims. In addition to providing core claims processing operations for both Part A and Part B, the MAC will be the primary contact for physicians and perform functions related to: Appeals, Provider Outreach and Education, Financial Management, Provider Enrollment, Reimbursement, Payment Safeguards, and Information Systems Security.

Per CMS, "The successful implementation of MAC contracts represents a first step in CMS' initiatives designed to improve service to beneficiaries and providers, support the delivery of coordinated and quality care, and provide greater administrative efficiency and effectiveness for fee-for-service Medicare." ***For further information regarding MACs please refer to the above mentioned website.***

MOST FREQUENTLY CITED TAGS ON SURVEY FOR THE LAST YEAR

HOME HEALTH:

TAG	DESCRIPTION	FREQUENCY CITED
G165	Conformance With Physician Orders	26
G158	Acceptance of Patients, POC, Medical Supervision	24
G118	Compliance with Federal, State, Local Laws	22
G236	Clinical Records	19
G108	Right To Be Informed and Participate	13
G229	Aide Supervision	12
G159	Plan of Care	11
G116	Home Health Hotline	9
G337	Drug Regimen Review	9
G145	Coordination of Patient Services	8

MOST FREQUENTLY CITED TAGS ON SURVEY FOR THE LAST YEAR CONT.

HOSPICES:

TAG	STATE/FEDERAL	DESCRIPTION	FREQUENCY CITED
M253	State	Facility Resident	26
M159	State	Plan of Care	15
M113	State	General Provisions	14
M157	State	Plan of Care	11
M168	State	Interdisciplinary Group	10
M104	State	Discontinuance of Hospice Care	8
M208	State	Clinical Services	8
M114	State	General Provisions	8
M231	State	Volunteers	8
L176	Federal	Central Clinical Records	7
M129	State	Patient Rights	7
M175	State	Clinical Services	7
M 176	State	Clinical Services	7
M195	State	Clinical Services	7
M222	State	Medications	7
M224	State	Medications	7
M244	State	Central Clinical Records	7

VOLUNTEERS

The Bureau has recently received multiple phone inquiries regarding what the requirements for volunteers are in regards to such things as criminal background checks, health screenings, Alzheimer's training, etc. This is just a reminder to hospice agencies that volunteers are required by regulation to meet the same requirements as any other patient care personnel.

STAY IN THE LOOP!

Are you in the loop with the latest home care and rehabilitation information? Join the HCRS list serve! You can subscribe and unsubscribe at any time. It is strongly recommended that each agency establish and utilize a permanent email address, one that is assigned to the agency administrator. This will ensure that the agency receives the latest information in a timely manner.

To subscribe to the **home health** list serve please go to:
http://cntysvr1.lphamo.org/mailman/listinfo/home_health

To subscribe to the **hospice** list serve please go to:
http://cntysvr1.lphamo.org/mailman/listinfo/hospice

To subscribe to the **opt/corf** list serve please go to:
http://cntysvr1.lphamo.org/mailman/listinfo/opt_corf

Share this information with others who may be interested. For list serve questions, contact Debi Siebert at (573) 751-6336 or Debi.Siebert@dhss.mo.gov

DISCHARGE FOR CAUSE

42 CFR Part 418.26 was revised and made effective January 23, 2006. This new provision specifies when a hospice may discharge a patient from its care, including (1) The patient moves out of the hospice's service area or transfers to another hospice; (2) The hospice determines that the patient is no longer terminally ill; or (3) The hospice determines that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

The hospice must advise the patient that a discharge for cause is being considered, make a serious effort to resolve the problem(s), determine that the patient's proposed discharge is not due to the patient's use of necessary hospice services; document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records. The hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

The hospice must also have in place a discharge planning process that includes planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

In the comments that accompany the final rule, CMS notes that a valid reason for discharge for cause would be failure to follow important clinical features of the plan of care. However, a panicked reaction to an emergency should not be, by itself, a reason to consider discharge.

The hospice agency would need a policy for the purpose of addressing "discharge for cause".

The bureau staff agree and understand that at no time should the agency send their personnel back into a home in which it is an unsafe environment, where the staff's life and/or welfare could be at risk.

LPN SUPERVISION

Another area that we get frequent inquiries about is L.P.N. supervision requirements for home health. Although there is no specific regulation for home health that specifies how often the L.P.N. must be supervised by the R.N., there are regulations that specify that there is to be supervision. CFR 484.30 (Tag G169) states "The HHA furnishes skilled nursing services by or under the supervision of a registered nurse; and…" This indicates that if the L.P.N. furnishes skilled nursing services it would be required to be under the supervision of a registered nurse. CFR 484.30(b) Interpretive Guidelines states "Determine if services are provided in accordance with the HHA's professional practice standards and with guidance and supervision from RNs." This would include reviewing duties of the LPN. CFR 484.30(b) also states (Tag G179) "The licensed practical nurse furnishes services in accordance with agency policies." When determining if this tag is met on survey, the surveyor would determine if L.P.N. supervision is being carried out according to your agency policy.

For Hospice agencies, state regulations (19 CSR 30-35.010 (2) (G) (1) (D)) specifically spells out that L.P.N. supervision is a requirement at least monthly. ML 173 and ML 174 states, " When nursing services are delegated to a licensed practical nurse: (i) The licensed practical nurse shall be supervised by a registered nurse who is available to the licensed practical nurse at least by phone during the hours that the licensed practical nurse is providing services or is on call; and (ii) The registered nurse shall make at least monthly on-site visits and document that the licensed practical nurse is routinely providing nursing services in accordance with the plan of care."

HALDOL FOR SNF HOSPICE PATIENTS

There continues to be issues with the use of Haldol for delirium or nausea in hospice patients who are residents of skilled nursing homes. It is very evident in the "hospice world" that the Haldol is not being used for chemical restraint; however, unless there is specific documentation in the patient's long term care (LTC) facility medical record, the LTC surveyor will cite the skilled facility for using the drug as a chemical restraint.

Therefore, the hospice agency needs to assure:

1) The order for that medication is in the patient's LTC chart.

2) There is documentation that an attempt was made to reduce the dose. If the physician determines it would be detrimental to try a dose reduction, then that too needs to be well documented.

Appendix "PP" of the Long Term Care regulations state, " ….the use of antipsychotic medications…requires a GDR (Gradual dose reduction) unless clinically contraindicated. Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. Af-

HALDOL FOR SNF HOSPICE PATIENTS

ter the first year, a GDR must be attempted annually, unless clinically contraindicated….For any individual who is receiving an antipsychotic medication to treat a psychiatric disorder other than behavioral symptoms related to dementia (for example, schizophrenia, bipolar mania, or depression with psychotic features), the GDR may be considered contraindicated, if:

- The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or
- The resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility and the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."

3) There is evidence of appropriate monitoring of side effects.

Therefore, it is imperative that hospice agencies make every attempt to assure all the necessary documentation is in the patient's LTC medical record. If it is not documented the LTC surveyor has no choice but to write a deficiency due to the LTC facility not complying with the regulations. This needs to be accomplished by communication between the hospice and LTC staff.

OASIS NEWS

(Please see ATTACHMENT #3)

BEREAVEMENT

The Bureau would like to remind all hospice agencies of the requirements for Bereavement Counseling. CFR 418.88(a) Bereavement Counseling Tag L 200 states, "The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to **one year** following the death of the patient)." The surveyors are finding that hospices are not always developing a 12-month bereavement plan as mandated by the regulation.

STANDING ORDERS

The surveyors continue to see problems on survey with standing orders. The Bureau has given reminders to hospice agencies in previous Bureau Talks, but feel a reminder is again necessary. Guidelines to remember when developing your agency's standing orders are:

- Each procedure, medication or treatment should be addressed in a separate order on the overall standing orders
- Each procedure, medication or treatment should have specific criteria or qualifications for use such as the medical indication, purpose or conditions of use. These criteria should be as specific as possible and not allow nurses' choice.
- Standing orders should **not** include normal teaching processes, instructions to caregivers, etc.
- Standing orders must be signed and dated by the physician.
- Medical Director must review all standing orders annually.
- There should be policies in place as to when and how to use the standing orders and a method to show physician notification of use of standing orders.
- Standing orders must be patient individualized.
- No narcotics on standing orders.

2008 ANNUAL STATISTICAL REPORTS

The 2007 Annual Statistical Report Statewide Percentages have just been tabulated and we are already talking about the 2008 reports!

This is to inform all agencies that the 2008 statistical reports will collect the exact same information as the 2007 report. However, there are a couple areas on the report that the Bureau requests that ***hospice*** agencies pay particular attention to, when collecting the data for the 2008 report.

- *Number of Persons not Admitted* – Please attempt to identify the category that best fits the scenario and use the category "other" only if absolutely necessary. On the 2007 report 26.34% of the patients not admitted were marked by hospice agencies as "other".
- *Admissions by Race/ethnicity* – On the 2007 report 5.31% of the patients were marked as "don't know" for race/ethnicity by hospice agencies. If a hospice agency does not know the patient's race/ethnicity they should inquire by asking the patient or caregiver. "Don't know" is unacceptable in most situations.